THE HENRY J. KAISER FAMILY FOUNDATION

THE KAISER COMMISSION ON
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Implications of the New Medicare Prescription Drug Benefit for State Medicaid Budgets

For a number of years, Governors and other state policymakers have maintained that Medicare – rather than state Medicaid programs – should play the key role in providing prescription drug coverage to Medicare beneficiaries, including those who also qualify for Medicaid (i.e, the "dual eligibles").[i] The Medicare prescription drug bill signed into law by President Bush on December 8, 2003 includes dual eligibles in the new Medicare drug benefit as of January 1, 2006.[ii] Although the new law shifts drug coverage for dual eligibles from Medicaid to Medicare, it does not provide full fiscal relief to states or guarantee equivalent coverage to dual eligibles. A number of provisions in the law may actually adversely affect state Medicaid budgets and offset much of the Medicaid fiscal relief that state policymakers had long expected would accompany the adoption of a prescription drug benefit in Medicare.

This issue brief describes the key provisions of the new Medicare prescription drug benefit in terms of the potential impact on state Medicaid programs and budgets; reviews the Congressional Budget Office estimates available at this time on the effect of these provisions on state Medicaid expenditures; and discusses why the fiscal impact of the new Medicare prescription drug benefit on Medicaid budgets can be expected to vary widely across states. It does not address other provisions of the new Medicare law with a potential impact on states, many of which are not related to the creation of a new prescription drug benefit in Medicare (e.g., the law contains new Medicaid funds for payments to hospitals that serve a disproportionately large number of uninsured and Medicaid patients). Information on the overall effect of the law on states is not currently available from the Congressional Budget Office or other sources.

I. Key Provisions of the New Medicare Prescription Drug Benefit Affecting State Medicaid Budgets

Some of the most significant changes in the new law affecting state Medicaid spending include the following:

- **Dual eligibles are expected to secure drug coverage through Medicare; Medicaid no longer will finance drug coverage for this population.** As of January 1, 2006, dual eligibles are expected to secure their prescription drug coverage through Medicare under the new "Part D" of the program. On that date, states no longer can secure federal Medicaid matching funds for the cost of providing prescription drug benefits to dual eligibles who are eligible to enroll in Part D.[iii] As a result, states no longer will have to expend state Medicaid matching funds on providing prescription drug coverage to dual eligibiles. If dual eligibles do not enroll in a Part D plan or if they need more drug coverage than is

provided by their Part D plans, states can provide it to them using 100 percent state funds. The federal government, however, will not provide states with Medicaid matching funds for such expenditures.

- **Continued state financing of much of the prescription drug costs for dual eligibles through "clawback payments".** States are required to continue to finance much of the cost of providing the new Medicare Part D benefit to dual eligibles on an ongoing basis through monthly maintenance-of-effort or "clawback" payments to the federal government. The payments are designed to return to the federal government a significant share of the amount states would have spent on dual eligibles' prescription drug coverage under Medicaid if the new Medicare law had not been enacted. The share of such expenditures, described as the "takeback" share, is set at 90 percent in 2006 and tapered down to 75 percent for 2015 and later years. The size of the clawback payments for any given state in any given month will be determined by a complex formula, primarily based on the state's per capita expenditures on Medicaid prescription drugs for dual eligibiles in 2003 trended forward by per capita growth in prescription drug spending nationwide since 2003[iv]; the number of dual eligibles in the state who are enrolled in the new Part D program in the month in question; and the "takeback" share for the month in question.

- **Significant new responsibilities for administering Medicare's low-income subsidy program.** The law requires state Medicaid agencies and Social Security Offices to accept and evaluate the applications of Medicare beneficiaries seeking assistance under Medicare's Part D low-income subsidy program. The new Part D program will provide assistance with the Part D premium, deductible and cost-sharing obligations to Medicare beneficiaries with income below 150 percent of the poverty line who can meet an asset test. Over 14 million seniors are expected to be eligible for the new subsidy program in 2006, although not all of them are expected to participate.[v] Among those who do participate, a significant share may apply for coverage through Social Security Offices.[vi] However, even if a small share of eligible Medicare beneficiaries apply for assistance at state Medicaid agencies, states will incur new Medicaid administrative expenses as they hire staff and modify their computer systems to accommodate the applicants. Moreover, states are required to screen the Medicare beneficiaries seeking low-income subsidies for eligibility for selected categories of Medicaid eligibility that provide assistance with Medicare premium and/or cost-sharing obligations (i.e., the "Medicare Savings Programs"). If states find someone who is eligible for such assistance, they must offer the individual the chance to enroll in Medicaid. As a result, the new Part D low-income subsidy program is expected to have a "woodwork" effect that increases state Medicaid expenditures.

II. Overall Impact on State Medicaid Expenditures

In a November 20, 2003 letter to Senator Don Nickles, the Congressional Budget Office provided estimates of the effect on state Medicaid expenditures of the three provisions

described above. According to CBO, the elimination of Medicaid-financed prescription drug coverage for dual eligibles will reduce state Medicaid spending by some $115 billion between federal fiscal year 2004 and 2013. Over the next ten years, however, CBO estimates suggest that states will see 85 percent of this $115 billion in Medicaid fiscal relief disappear due to the mandatory clawback payments ($88.5 billion), higher enrollment in Medicaid when people come into Medicaid offices to apply for the Part D low-income subsidy program ($5.8 billion), and new administrative responsibilities ($3.1 billion). The net fiscal relief to state Medicaid programs over the next ten years is expected to total $17.2 billion. Nearly 80 percent of this fiscal relief is expected to occur in the last four years (2010 – 2013) of the 10-year period evaluated by CBO.

In the short-term, the Congressional Budget Office estimates suggest that the new law will actually increase state Medicaid spending. Between fiscal year 2004 and 2006, new state Medicaid costs due to the Medicare bill are expected to exceed Medicaid fiscal relief by $1.2 billion. The primary reason for the net expense to state Medicaid budgets in the short-term appears to be that states' clawback payments to the federal government in 2006 are expected to exceed the amount of fiscal relief states will secure as a result of no longer providing Medicaid-financed prescription drug coverage to dual eligibles.

While the CBO estimates assess the impact of some of the major changes in the Medicare law related to the new prescription drug benefit, they are not designed to represent a comprehensive assessment of the law on state finances. They do not take into account provisions unrelated to prescription drug coverage that may benefit states, such as an increase in federal funds available for disproportionate share hospital (DSH) payments; an extension of funding for a Medicaid program that pays the Medicare Part B premiums of selected beneficiaries with income up to 135 percent of poverty (i.e., the "QI-1 program"); and new funds for providing health care services to undocumented immigrants. They also do not take into account states' savings on the cost of drug coverage for retired state employees or State Pharmacy Assistance Programs, or new Medicaid costs for dual eligibles that states are expected to incur due to the increase in Part B deductibles.

III. State-by-State Variation in the Impact of the Medicare Law on Medicaid Budgets

The CBO estimates of the impact on state Medicaid budgets of key provisions of the new Medicare law suggest that nationwide states may retain roughly 15 percent of the fiscal relief they otherwise would secure as a result of no longer providing prescription drug coverage to dual eligibles. For any given state, however, the impact could vary significantly from this nationwide figure. Given the complexity of the law, it is likely to be some time before state-by-state estimates of its impact are available, but the following factors are likely to play a key role in determining how states fare:

- **The trajectory of state Medicaid spending on prescription drugs for dual eligibles in the absence of the Medicare law**. The clawback payments that states must make each month to offset the cost to the federal government of

providing Part D drug coverage to dual eligibles are based in part on national growth over time in per capita prescription drug expenditures. Under their Medicaid programs, however, some states likely would have seen the per capita cost of providing prescription drug expenditures to dual eligibles rise more rapidly than a nationwide average, while other states would have experienced relatively modest growth. The states that would have experienced relatively modest growth, however, still must make payments to the federal government based on a nationwide trend.

- **State Medicaid expenditures on prescription drugs for dual eligibles in 2003.** A second key factor in determining the size of each state's clawback payments to the federal government for Part D benefits is its per capita state Medicaid expenditures on prescription drugs for dual eligibles in 2003. This figure varies widely across states because some states offer more comprehensive prescription drug benefits and/or are currently more aggressive about adopting cost-control measures than others. The clawback formula effectively freezes these state-by-state variations in place, requiring states that offered relatively expensive benefits to pay the federal government more than their counterparts with narrower benefits or more aggressive cost controls. (Table 1 provides state-by-state information on per capita state Medicaid expenditures for prescription drugs for dual eligibles in 2002, the latest year for which data are available. These figures vary for the reasons noted above, and because states have different federal Medicaid matching rates. The clawback formula takes into account changes over time in states' Medicaid matching rates).

- **The number of dual eligibiles in each state who enroll in the new Part D benefit.** The cost of the new Medicare law in any given state will depend on the number of dual eligibles who enroll in the new Part D benefit. In 2006, the size of states' clawback payments to the federal government is expected to increase by an average of $1,260 for each dual eligible who enrolls in Medicare Part D coverage.[vii] (The fiscal cost to an individual state associated with the enrollment of a dual eligible in Part D will vary widely because it is based on each state's expenditures on prescription drugs for dual eligibles in 2003 trended forward at a national growth rate.) Since states' clawback payments are determined in part based on the number of dual eligibles who enroll in Part D coverage, the new law actually creates an incentive for states to reduce the size of their dual eligible populations with Part D benefits to reduce the burden of their clawback payments.

- **Whether a state decides to supplement the Part D benefit in any way.** The impact of the Medicare law on state Medicaid budgets also will depend on whether a state elects to use its own funds without federal Medicaid matching to address gaps for dual eligibles if Part D plans do not cover the full array of drugs that are needed due to restrictive formularies or if the Part D cost-sharing obligations exceed the amount a state deems reasonable for dual eligibles. Given that states are facing ongoing fiscal problems, many states may not elect to use state-only funds to fill gaps in Part D coverage or may elect to to fill some of the

Table 1

"Full" Dual Eligible Enrollment and Prescription Drug Spending, by State, 2002

State	Enrollment: Full Dual Eligibles	Spending on "Full" Duals (millions): Total	Spending on "Full" Duals (millions): Prescribed Drugs	Prescribed Drugs as % of Total	State Per-Capita Spending on Prescribed Drugs (State Dollars Only)
United States	6,126,000	$91,056	$13,177	14%	$918
Tennessee	191,000	$2,058	$197	10%	$375
Arkansas	98,000	$1,010	$151	15%	$422
Mississippi	133,000	$1,092	$258	24%	$463
New Mexico	27,000	$405	$47	12%	$466
Alabama	121,000	$1,349	$193	14%	$470
Oklahoma	77,000	$869	$123	14%	$471
South Carolina	117,000	$1,199	$192	16%	$503
District of Columbia	17,000	$287	$29	10%	$504
West Virginia	36,000	$634	$77	12%	$529
Hawaii	26,000	$250	$32	13%	$529
Arizona	57,000	$765	$91	12%	$562
Montana	15,000	$207	$33	16%	$591
North Dakota	13,000	$272	$28	10%	$656
Louisiana	109,000	$1,300	$252	19%	$687
South Dakota	14,000	$240	$29	12%	$707
Texas	363,000	$4,956	$654	13%	$717
Kentucky	172,000	$1,961	$418	21%	$730
Idaho	10,000	$163	$28	17%	$799
Pennsylvania	306,000	$3,339	$554	17%	$822
Michigan	190,000	$1,891	$358	19%	$822
Iowa	55,000	$911	$124	14%	$838
Maine	42,000	$645	$106	16%	$843
California	904,000	$8,290	$1,652	20%	$888
North Carolina	225,000	$2,824	$527	19%	$903
Nevada	18,000	$208	$33	16%	$910
Utah	17,000	$263	$52	20%	$913
Georgia	129,000	$1,622	$298	18%	$947
Nebraska	35,000	$533	$82	15%	$949
Wyoming	6,000	$128	$15	12%	$956
Vermont	22,000	$248	$58	23%	$977
Wisconsin	115,000	$2,082	$274	13%	$988
Massachusetts	193,000	$3,638	$408	11%	$1,058
Kansas	39,000	$792	$109	14%	$1,110
Indiana	103,000	$1,828	$301	16%	$1,110
Rhode Island	27,000	$715	$63	9%	$1,114
New York	537,000	$15,217	$1,200	8%	$1,117
Alaska	9,000	$144	$24	17%	$1,122
Oregon	56,000	$766	$156	20%	$1,134
Ohio	179,000	$4,401	$496	11%	$1,142
Missouri	138,000	$1,983	$408	21%	$1,152
Florida	354,000	$3,933	$937	24%	$1,153
Colorado	59,000	$1,014	$137	14%	$1,162
Virginia	101,000	$1,450	$243	17%	$1,166
Illinois	171,000	$2,976	$423	14%	$1,237
Minnesota	92,000	$2,194	$232	11%	$1,258
Washington	93,000	$1,007	$239	24%	$1,275
Maryland	71,000	$1,368	$182	13%	$1,282
Delaware	9,000	$236	$24	10%	$1,313
Connecticut	76,000	$2,252	$201	9%	$1,322
New Jersey	140,000	$2,684	$381	14%	$1,359
New Hampshire	19,000	$455	$52	11%	$1,371

Source: Kaiser Commission on Medicaid and the Uninsured estimates based on Urban Institute analysis of MSIS and Medicaid Financial Management Reports, as presented in Bruen and Holahan, *Shifting the Cost of Dual Eligibiles: Implications for States and the Federal Government* , The Kaiser Commission on Medicaid and the Uninsured, November 2003, available at http://www.kff.org/kcmu.

gaps only for selected groups, such as the mentally ill or HIV-positive individuals who may be particularly vulnerable if they experience a deterioration in coverage.

While it is impossible at this time to assess how these, as well as other factors, will affect individual states, some states undoubtedly will fare better than others. States with relatively comprehensive Medicaid prescription drug benefits are likely to fare less well than their counterparts with more limited coverage because they are likely to face large maintenance-of-effort payments to the federal government due to their per capita expenditures on prescription drugs for dual eligibles in 2003. At the same time, the tradition of providing comprehensive prescription drug coverage to dual eligibles may lead policymakers in these states to feel particularly compelled to use state funds to address some of the gaps that could emerge in the scope of the Part D coverage available to dual eligibles.

Conclusion

It will likely be some time before individual states are able to fully evaluate the effect of the new Medicare prescription drug benefit on their Medicaid budgets and dual eligible populations. For now, however, it seems clear that the law provides substantially less Medicaid fiscal relief than states had long expected would accompany the addition of a prescription drug benefit to Medicare, as well as raises a number of questions regarding how dual eligibles will fare under the new Medicare law. Because of the diversity in states' situations and policies, wide variation in the impact on states and their budgets can be expected.

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[i] Unless otherwise noted, "dual eligible" is used throughout this issue brief to refer to individuals with both Medicaid and Medicare coverage who are entitled to full Medicaid benefits. It does not include individuals, often known as "partial dual eligibles," who are eligible for assistance from Medicaid only with their Medicare cost-sharing obligations.

[ii] H.R. 1, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The law does not simply add a prescription drug benefit to Medicare, but also makes a number of other changes to the Medicare program, Medicaid, prescription drug policy, and other areas. This issue brief, however, addresses primarily only those provisions of H.R. 1 related to the new Medicare prescription drug benefit that affect Medicaid.

[iii] The bar on receiving federal Medicaid matching funds for prescription drug coverage extends to all dual eligibiles with full Medicaid benefits covered under state plan amendments, including dual eligibles covered at state option. One exception is that states can secure Medicaid matching funds for providing drugs to dual eligibiles that Part D plans are not allowed to cover. The classes of drugs that fall under this exemption are: 1) anorexia, weight loss, or weight gain drugs; 2) fertility drugs; 3) drugs used for cosmetic purposes or to promote hair growth; 4) medicines used for the symptomatic relief of cough and colds; prescription vitamins and mineral products (except prenatal vitamins and fluoride preparations); 5) over-

the-counter drugs; 6) barbiturates; and 7) benzodiazepines. The law does not clearly address the issue of whether states can continue to receive federal Medicaid matching funds for the cost of providing prescription drug benefits to seniors and people with disabilities covered under Medicaid Section 1115 waivers.

[iv] The measure of national growth in per capita prescription drug expenditures will be based on National Health Expenditure Survey estimates of per capita prescription drug spending growth through 2006 and on the growth in per capita Part D spending in 2007 and later years. The law provides more detail on the formula than is presented here, but also leaves a number of issues unresolved. For example, the law is ambiguous as to whether the per capita expenditure figure that is used in the clawback formula will be based on total Medicaid prescription drug spending in 2003 divided by the number of dual eligibles or the total Medicaid prescription drug spending in 2003 on dual eligibles divided by the number of dual eligibles.

[v] Congressional Budget Office, letter to Senator Don Nickles, Chairman, Committee on the Budget, November 20, 2003.

[vi] Even if subsidy-eligible individuals apply for assistance through Social Security Offices, states may have a role to play in their eligibility determinations because the level of subsidy that someone receives depends on whether he or she is a dual eligible. Thus, depending on how the option to apply for coverage through Social Security Offices is implemented, states may need to provide or verify information on the Medicaid status of dual eligibiles when they seek to enroll in the new low-income subsidy program through a Social Security Office.

[vii] KCMU estimates based on trending forward the average per capita state expenditure on prescription drug coverage for dual eligibles in fiscal year 2002 by national projected growth in per capita prescription drug spending through 2006. The resultant figure was multiplied by 90 percent to approximate the average amount by which states' clawback payments will increase in 2006 per additional dual eligible enrolled in Part D. The data on average state expenditures per dual eligible in 2002 were provided by the Urban Institute and projections of per capita growth in prescription drug expenditures through 2006 were taken from National Health Expenditure Survey Projections prepared by CMS, Office of the Actuary, February 2003.